

EXHIBIT 2

SCI DOC ID

754623

Summary Plan Description

Danaher Corporation

80/20 Plan Option 1
and
90/10 Plan Option 2

Effective: January 1, 2011
Group Number: 717473



RIGHT HAND PAGE

TABLE OF CONTENTS

SECTION 1 - WELCOME	1
SECTION 2 - INTRODUCTION	2
Your Medical Plan Election	2
Eligibility for Coverage	3
Enrollment and Effective Dates	5
Dependent Child Special Open Enrollment Period	8
SECTION 3 - HOW THE PLAN WORKS	10
Network and Non-Network Benefits	10
Eligible Expenses	11
Annual Deductible	11
Copayment	11
Coinsurance	12
Out-of-Pocket Maximum	12
SECTION 4 - PERSONAL HEALTH SUPPORT	14
Requirements for Notifying Personal Health Support	15
SECTION 5 - PLAN HIGHLIGHTS	18
SECTION 6 - ADDITIONAL COVERAGE DETAILS	27
Ambulance Services	27
Bariatric Surgery	27
Cancer Resource Services (CRS)	28
Congenital Heart Disease (CHD) Surgeries	29
Dental Services	30
Diabetes Services	32
Durable Medical Equipment (DME)	32
Emergency Health Services - Outpatient	34
Home Health Care	34
Hospice Care	35
Hospital - Inpatient Stay	35

[APG]

TABLE OF CONTENTS

Lab, X-Ray and Diagnostics - Outpatient.....	36
Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.....	36
Nutritional Counseling.....	36
Ostomy Supplies	37
Pharmaceutical Products - Outpatient.....	37
Physician Fees for Surgical and Medical Services	37
Physician's Office Services - Sickness and Injury.....	37
Pregnancy - Maternity Services	38
Preventive Care Services.....	39
Prosthetic Devices	39
Reconstructive Procedures	40
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.....	41
Scopic Procedures - Outpatient Diagnostic and Therapeutic.....	42
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	42
Surgery - Outpatient.....	43
Temporomandibular Joint (TMJ) Services.....	44
Therapeutic Treatments - Outpatient.....	44
Transplantation Services	45
Travel and Lodging – Network or United Resource Networks only.....	46
Urgent Care Center Services	47
Vision Examinations	47
Wigs.....	47
SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY	48
Consumer Solutions and Self-Service Tools.....	48
Disease and Condition Management Services	52
Wellness Programs.....	53
SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER.....	54
Alternative Treatments.....	54
Dental	54
Devices, Appliances and Prosthetics.....	55
Drugs	56

[APG]

TABLE OF CONTENTS

Experimental or Investigational or Unproven Services	56
Foot Care	56
Medical Supplies and Equipment.....	57
Nutrition.....	58
Personal Care, Comfort or Convenience	58
Physical Appearance.....	59
Procedures and Treatments.....	60
Providers	61
Reproduction	61
Services Provided under Another Plan.....	62
Transplants.....	62
Travel.....	62
Types of Care.....	63
Vision and Hearing.....	63
All Other Exclusions	63
SECTION 9 - CLAIMS PROCEDURES.....	65
Network Benefits	65
Non-Network Benefits	65
If Your Provider Does Not File Your Claim.....	65
Health Statements	66
Explanation of Benefits (EOB)	66
Claim Denials and Appeals.....	67
Federal External Review Program.....	68
Limitation of Action.....	71
SECTION 10 - COORDINATION OF BENEFITS (COB).....	72
Determining Which Plan is Primary	72
When This Plan is Secondary.....	73
When a Covered Person Qualifies for Medicare.....	74
Right to Receive and Release Needed Information.....	75
Overpayment and Underpayment of Benefits.....	75
SECTION 11 - SUBROGATION AND REIMBURSEMENT	77
Right of Recovery	77

[APG]

TABLE OF CONTENTS

Right to Subrogation	77
Right to Reimbursement.....	78
Third Parties	78
Subrogation and Reimbursement Provisions	78
SECTION 12 - WHEN COVERAGE ENDS	81
Coverage for a Disabled Child.....	82
Continuing Coverage Through COBRA.....	82
When COBRA Ends	86
Uniformed Services Employment and Reemployment Rights Act.....	86
SECTION 13 - OTHER IMPORTANT INFORMATION	88
Qualified Medical Child Support Orders (QMCSOs)	88
Your Relationship with UnitedHealthcare and Danaher Corporation	88
Relationship with Providers	89
Your Relationship with Providers	89
Interpretation of Benefits	90
Information and Records.....	90
Incentives to Providers	91
Incentives to You.....	91
Rebates and Other Payments	92
Workers' Compensation Not Affected.....	92
Future of the Plan	92
Plan Document	92
SECTION 14 - GLOSSARY	93
SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA.....	106
ATTACHMENT I - HEALTH CARE REFORM NOTICES.....	110
Patient Protection and Affordable Care Act ("PPACA")	110

[APG]

TABLE OF CONTENTS

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

[APG]

SECTION 10 - COORDINATION OF BENEFITS (COB)

DANAHER CORPORATION MEDICAL PLAN

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

[APG]

SECTION 10 - COORDINATION OF BENEFITS (COB)

- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

If This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

[APG]

SECTION 10 - COORDINATION OF BENEFITS (COB)

- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Plan Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If Danaher Corporation pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Danaher Corporation if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment Danaher Corporation made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

[APG]

SECTION 10 - COORDINATION OF BENEFITS (COB)

The refund equals the amount Danaher Corporation paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help Danaher Corporation get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, Danaher Corporation may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. Danaher Corporation may have other rights in addition to the right to reduce future Benefits.

[APG]

SECTION 10 - COORDINATION OF BENEFITS (COB)

SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a

[APG]

SECTION 11 - SUBROGATION AND REIMBURSEMENT